Ontario

**Ministry of Health**

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5
Tel: 416-327-8804
Toll-Free: 1-800-268-6021
TTY: 416-327-4282
TTY: 1-800-387-5559

# Application for Funding Enteral Feeding Pump and Supplies

*EF1*

## Section 1 – Applicant's Biographical Information

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Health Number (10 digits) | Version | Date of Birth (yyyy/mm/dd) |
|---|---|---|
| | | |

Name of Long-Term Care Home (LTCH) (if applicable)

**Address**

| Unit Number | Street Number | Street Name |
|---|---|---|
| | | |

| Lot/Concession/Rural Route | City/Town | Province | Postal Code |
|---|---|---|---|
| | | ON | |

| Home Telephone Number | Business Telephone Number ext. |
|---|---|
| | |

**Confirmation of Benefits**

I am receiving social assistance benefits ☐ Yes ☐ No

If yes, please check one
- ☐ Ontario Works Program (OWP)
- ☐ Ontario Disability Support Program (ODSP)
- ☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Enteral Feeding Pumps or Supplies from
- Workplace Safety & Insurance Board (WSIB) ☐ Yes ☐ No
- Veterans Affairs Canada (VAC) – Group A ☐ Yes ☐ No

I am a resident of a Long-Term Care Home (LTCH) ☐ Yes ☐ No

I am a patient of an acute or a chronic care hospital ☐ Yes ☐ No

## Section 2 – Devices and Eligibility (to be completed by Prescriber)

**Devices Required**

Enteral Feeding Pump (check one) ☐ Stationary ☐ Portable

**Supplies Required**

☐ Enteral Feeding Supplies

**Reason for Application (check one)**

☐ First access to ADP for Enteral Feeding Pump

☐ Replacement of Enteral Feeding Pump

**Replacement Pump Required Due To (check as appropriate)**

☐ Change in medical condition

☐ Current device not in good working order and applicant confirms that it is no longer under warranty

- ☐ Vendor/Manufacturer's repair quote attached (other attachments will not be considered)

**Confirmation of Applicant's Eligibility (answers required to all the statements)**

To be completed by a Physician or Nurse Practitioner

Please confirm the following Eligibility Criteria for **Enteral Feeding Pump and/or Supplies**

Applicant has mechanical or functional impairment requiring intervention of Enteral Feeding ☐ Yes ☐ No ☐ N/A

Please confirm the following Eligibility Criteria for **Enteral Feeding Pump only**

Applicant requires feeds to be delivered by a pump for six hours or more over a 24-hour period ☐ Yes ☐ No ☐ N/A

Please confirm the following Eligibility Criteria for **Portable Enteral Feeding Pump only**

Applicant is increasingly active and ambulatory and requires feeds to be delivered by a portable pump ☐ Yes ☐ No ☐ N/A

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| Applicant's Last Name | First Name | Health Number (10 digits) | Version |
|---|---|---|---|
| | | | |

## Section 3 – Applicant's Consent & Signature

**Note: This section of the form may be signed only by the applicant or his or her agent**

I consent to the Ministry of Health (the Ministry) collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive benefits under the Ministry's Assistive Devices Program (the "Program"). In addition, I consent to the Ministry and the Workplace Safety and Insurance Board (WSIB) collecting, using and disclosing personal information about me, including the information on this form and information related to my entitlement to health care benefits under the *Workplace Safety and Insurance Act* ("WSIA"), for the purpose of assessing and verifying my eligibility to receive benefits under the Program and WSIA.

The Ministry and WSIB will limit the information that they exchange about me to only that information that is necessary for the purpose above.

The Ministry will only use and disclose my personal health information in accordance with the *Personal Health Information Protection Act*, 2004, and the Ministry's "Statement of Information Practices" which is accessible at: www.health.gov.on.ca. In addition, the WSIB will collect, use and disclose personal information about me from the Ministry for the purpose of administering and enforcing the WSIA.

I understand that if I choose to withhold or withdraw my consent to the collection, use and disclosure of this information by the Ministry or WSIB, I may be denied coverage under the Program.

For more information on the Ministry's Information Practices, or the collection of the personal health information on this form, call 1-800-268-6021/416-327-8804 or TTY: 416-327-4282 or write to the Program Manager, 5700 Yonge Street, 7th floor, Toronto ON M2M 4K5.

I have read the Applicant Information Sheet, understand the rules of eligibility for ADP and am eligible for the equipment specified.

I certify that the information I have provided on this form is true, correct and complete to the best of my knowledge. I understand that this information is subject to audit.

**Please indicate the payee and authorize by signature below**

☐ Payment to Applicant ☐ Payment to Agent (provide contact info below)

| Signature | ☐ Applicant ☐ Agent | Date (yyyy/mm/dd) |
|---|---|---|
| | | |

**If designated payee or signature above is not that of the applicant, specify relationship and complete contact information below**

☐ Spouse

☐ Parent

☐ Legal Guardian

☐ Public Trustee

☐ Power of Attorney

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

**Address**

| Unit Number | Street Number | Street Name | | |
|---|---|---|---|---|
| | | | | |
| **Lot/Concession/Rural Route** | **City/Town** | | **Province** | **Postal Code** |
| | | | ON | |

| Home Telephone Number | Business Telephone Number ext. |
|---|---|
| | |

| Applicant's Last Name | First Name | Health Number (10 digits) | Version |
|---|---|---|---|
| | | | |

## Section 4 – Signatures

**Physician/Nurse Practitioner Signature**

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic physical disability requiring regular use of the prescribed Enteral Feeding device/supplies.

☐ Physician ☐ Nurse Practitioner

| Physician/Nurse Practitioner's Last Name | Physician/Nurse Practitioner's First Name |
|---|---|
| Business Telephone Number ext. | Ontario Health Insurance Billing No (6 digits) |

| Physician/Nurse Practitioner's Signature | Date Signed (yyyy/mm/dd) |
|---|---|
| | |

**Note: Attach vendor/manufacturer's quote and/or repair bills if required (see Section 2)**
**Other attachments will not be considered by the Assistive Devices Program**

**It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding.**